Modify existing I.C.U./Emergency Training Programs - on the job training

REPORT OF THE WORKING GROUP ON

SPECIALTY TRAINING PROGRAMS

(NURSING)

TO THE URBAN HOSPITAL COUNCIL

JULY 31, 1991

Revised March 4, 1992

FINAL REPORT

URBAN HOSPITAL WORKING GROUP ON SPECIALTY TRAINING PROGRAMS (NURSING)

In April 1991, a Working Group was established by the Urban Hospital Council. The members of the Working Group are appended as Schedule I.

The terms of reference of the Working Group are:

(1) Identify the current specialty training programs (Adult Intensive Care, Emergency, Neonatal/Pediatric Critical Care) being provided.

(2) Review and comment on the impact of modifying the present system to a core program with modular on the job training.

(3) Identify an implementation plan for any recommended changes in the present specialty training program.

The Working Group met three times during which 5 specialty training programs that could possibly be incorporated into a concept consisting of a core program and related modules were identified as follows:

1. Adult Intensive Care Nursing Program * - Health Sciences Centre

2. Neonatal Pediatric Critical Care Nursing Program - Health Sciences Centre

3. Manitoba Emergency Nursing Program - Health Sciences Centre

4. Adult Intensive Care Nursing Program * - St. Boniface General Hospital

5. Critical Care Nursing Education Program (includes Intensive Care, Emergency and Recovery Room) - Brandon General Hospital

* THESE PROGRAMS ARE IN COLLABORATION WITH THE UNIVERSITY OF MANITOBA AND GRADUATES OF THE PROGRAM RECEIVE 12 CREDITS TOWARDS A BACHELOR OF NURSING.

The details of the five specialty training programs being considered for a core program are:

Name of Hospital/Course	Length of Course	Numbers of Students Annually	Student* Stipend	Teachers E.F.T.	Support Staff E.F.T.
Health Sciences Centre					
1. Adult Intensive Care Nursing Program	29 Weeks	40	$13,050	4.6**	.5
2. Neonatal Pediatric Critical Care Nursing Program	28 Weeks	16	$ 9,600	2.0	.5
3. Manitoba Emergency Nursing Program	30 Weeks	8	$ 6,000	2.0	.5
St. Boniface General Hospital					
1. Adult Intensive Care Nursing Program	29 Weeks	46 (this includes 6 students from urban & rural community hospitals)	$13,050	5.4**	1.0
Brandon General Hospital					
1. Critical Care Nursing (I.C.U., Emergency and Recovery Room)	30 Weeks	usually 5	$21,430	1.0	0.0

* This student stipend is for the total time in the program.

** Includes Director of Program.

General discussion during the three meetings brought forward the following points:

1. The Manitoba Emergency Nursing Program.

   - Teacher/Student ratio is high compared to other 4 programs.

   - It is the only hospital based emergency nursing education program in Canada.

   - This course does not affect the availability of direct care nursing manpower as it is not a prerequisite for employment in any of the emergency departments. However in some hospitals it is a prerequisite for emergency nursing administrative positions eg. Head Nurse.

   - Payback in time is not a requirement for nurses following graduation.

2. Adult Intensive Care Nursing Programs at the Health Sciences Centre and the St. Boniface General Hospital

   Collaboration with the University of Manitoba has made the program more attractive to students. Both teaching hospital programs have full enrollment. There are presently fewer staff vacancies in the two units than in previous years. The collaborative university model for gaining credits for Intensive Care Courses has proven effective. However two concerns have been expressed:

   (a) Dispensation of tuition dollars.

   (b) Scheduling of the program.

3. Student Stipend and Pay Back

   Each specialty program has a different student stipend and not all the courses require time pay back.

4. Educational Needs of Nurses in Urban and Rural Community Hospitals

   Any changes in the present programs must take into consideration the educational needs of nurses in urban and rural community hospitals.

5. Orientation Costs

   Orientation costs for nurses who have not graduated from a specialty program are expensive.

6. Specialty Education for Critical Care Areas

There is a need for specialty education programs in the critical care areas identified that is, emergency care; plus adult, pediatric and neonatal intensive care.

7. University Affiliation

The feasibility of receiving academic credit for specialty education programs needs to be explored with the University of Brandon School of Nursing in order to make the program more attractive for the students in the Westman region.

RECOMMENDATION 1

It is recommended that a Steering Committee investigate the feasibility of a core curriculum program for critical care nursing education.

IMPLEMENTATION FOR RECOMMENDATION 1

1. The Steering Committee will need to be formed as quickly as possible and would include representation from:

   - University of Manitoba - School of Nursing
   - Brandon University - School of Nursing
   - Brandon General Hospital
   - Health Sciences Centre
   - St. Boniface General Hospital
   - Two rural community hospitals (one to be specifically from the north)
   - Two urban community hospitals
   - Manitoba Health Services Commission
   - Manitoba Air Ambulance Program

   (Two of these representatives will be direct care nurses)

2. The Steering Committee would develop the terms of reference for a feasibility study for the proposed core curriculum program and carry out the study.

3. The Steering Committee would complete their study and have the core program developed by September 1, 1993.

4. The Steering Committee could be chaired jointly by the Manitoba Health Services representative and one other representative as chosen by the Steering Committee at its first meeting.

RECOMMENDATION II

On the advice of the Health Sciences Centre it is recommended that admissions to the Manitoba Emergency Nursing Education Program at the Health Sciences Centre be deferred for one year. This would allow a surplus of approximately $100,000 made up of 8 student positions, plus 1 teacher position for the time frame of September 1, 1991 to August 1, 1992. The second teacher position would be retained.

This Working Group concurs with the Health Sciences Centre recommendation.

IMPLEMENTATION FOR RECOMMENDATION II

1. The recommendation, if implemented September 1, 1991 would allow a surplus of $100,000 for an eleven month period from the starting date of implementation.

   The one time surplus of $100,000 would need to be reviewed at the end of the eleven month period by the Health Sciences Centre and the Urban Hospital Council.

PM/krms
Rev. August 7, 1991
Rpts/Spec-TR

SCHEDULE I

SPECIALTY TRAINING PROGRAMS (NURSING)

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PM/lg June 24/91
Comm/Spec

Manitoba

Health

Manitoba Health
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PO Box 925
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July 10, 1991

Heather Carlsson-Reid
President, EDNA of Manitoba
c/o 3204-197 Victor Lewis Drive
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Dear Ms Carlsson-Reid:

Thank you for your July 22, 1991 letter regarding the Manitoba Emergency Nursing Program.

The Working Group on Specialty Training Programs was established by the Urban Hospital Council with terms of reference related to the review of health care education programs presently being delivered in Manitoba.

One of the programs so reviewed was the Manitoba Emergency Nursing Program. A report recommending a general approach to the delivery of such programs and including a specific reference to the Manitoba Emergency Education Program will be presented to the Urban Hospital Council at its next meeting on August 7, 1991.

In recognition of the concerns expressed by you a copy of your letter will be attached to the report for the information and consideration of Council members.

Yours truly,

Phyllis MacDonald
Chair,
Working Group on Specialty
Training Programs (Nursing)

/krms

Ltrs/Reid

EMERGENCY DEPARTMENT NURSE'S ASSOCIATION of MANITOBA

E.D.N.A. of Manitoba Executive
C/O 3204-197 Victor Lewis Drive
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July 22, 1991

Members of the Urban Hospital Working Group
on Specialty Training Programs (Nursing)

Attention: Phyllis MacDonald, Senior Consultant
Urban Health Facilities Division
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Dear Sirs and Mesdames:

Recently the Emergency Department Nurses Association of Manitoba (EDNA), has become aware of the Urban Hospital Workir- Group on Specialty Training Programs (Nursing). It is ou understanding that the Manitoba Emergency Nursing Program (MENP at HSC) is one of the programs under review with recommendations for change. We further understand, that this includes the possibility of a one year deferment for the September 1991 MENP class, while exploration of a core curriculum program is investigated.

The primary concern of the EDNA Executive and membership is for the continuance of post basic emergency nursing education which reflects on the future of emergency nurses within the Province of Manitoba. During the fifteen years MENP has been offered, it has gained international recognition and is acknowledged by the National Emergency Nurses' Affiliation Inc. (NENA), as the prototype. The 135 MENP graduates have been instrumental in the development and continuing education of emergency nurses throughout the Province.

The NENA Position Statement "Role of the Nurse in Emergency Nursing Practice" (April 1988) (Appendix 1), outlines the specialty of Emergency Nursing.

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cc: Susan Derk, Executive Director, M.A.R.N.
Dorothy Froman, Consultant, Professional Development, M.A.R.N.
Judith Deatrich, Consultant, Nursing Practice, M.A.R.N.
Premier Gary Filmon
Honourable Donald W. Orchard, Minister of Health
Mrs. Sharon Carstairs, M.L.A.
Mr. Gary Doer, M.L.A.
Ms Judy Wasylycia-Leis, M.L.A.
Dr. G. S. Cheema - M.L.A.
NENA Inc. Board of Directors
Joan Jenkins, Director of Nursing Education and Research, HSC
Debra Vanance, Assistant Director of Specialty Programs, HSC

Emergency nursing's uniqueness is practicing with a limited data base, in an uncontrolled, unpredictable environment and within a variable time frame. Emergency Nursing encompasses expertise from many specialty areas such as maternal/child, medical/surgical, mental health, critical care, gerontology, primary care, and community health. Emergency nurses have a unique contribution to make to emergency care through an ability to address the broad range of patient and family needs. Inherent in the emergency nurses's role is the ability to organize and interpret data to expedite the most effective and appropriate intervention. It becomes vital that nurses practicing within this highly complex area should have expert clinical reasoning abilities to influence patient outcomes. (NENA Position Statement, "Role of the Nurse in Emergency Nursing Practice", April 1988)

Effective emergency nursing practice requires the acquisition of specific concepts which are not learned in basic nursing programs, or other critical care programs. These concepts include primary, focused, and secondary assessment skills and the complex specialty of triage. The goal is high quality, accurate assessment which leads to rapid and safe emergency care while optimally utilizing available resources. (NENA Position Statement, "Role of the Nurse in Emergency Nursing Practice", April 1988)

Most Canadians will attend a hospital Emergency Unit at some time in their lives, although they may not formally be admitted to a hospital as an inpatient. In 1986-1987 there were 3,747,470 admissions to Canadian hospitals; however, during the same period statistics indicate that there were 16,218,335 emergency visits (Statistics Canada, 1989). The ratio of emergency visits to hospital admissions is more than 4:1. This indicates, if the health consumer has contact with a hospital nurse, there is greater than 4:1 chance it will be an emergency nurse. This is representative of the national trend. (NENA Certification Document, 1987).

Life-threatening or emergent patients comprise a small percentage of the emergency department yearly census. The emergency nurse becomes a primary health care provider to the majority of the population who seek episodic care. Research done in 1975, (Sheehy, 1985), indicated that the breakdown of emergent, urgent, and non-urgent is as follows:

Emergent	2-5%
Urgent	10-15%
Non-urgent	60-80%

The emergency nurse is in a unique position to identify and intervene with vulnerable populations upon their arrival in the emergency department. Vulnerable groups include: the aboriginal,

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the elderly, the immigrant, the homeless, life threatened and primary health care consumers, family violence, sexual assault, and trauma victims. (NENA Position Statement, "Role of the Nurse in Emergency Nursing Practice", April 1988)

In March of 1991, Emergency Nursing in Canada, made it's mark in history. The Canadian Nurses Association (CNA) deemed Emergency Nursing to be the third designated specialty for certification; the first and second being, Neuroscience and Nephrology Nursing. The process to date took NENA almost 5 years to accomplish. We now enter Phase II, the development of the Emergency Certification Exam which will take a minimum of another two years. EDNA of Manitoba has been instrumental in the birth of this national project and has supported the idea and process throughout. The National Emergency Certification Committee was chaired these past 5 years by a Manitoba Emergency Nurse, Beth Brunsdon-Clark, who is an alumnus, educator, and past coordinator of the MENP, and one who was instrumental in the expansion and revision of the MENP curriculum.

Within the immense scope of Emergency Nursing Practice are recurrent phenomena. They are:

1. Emergency Environment;
2. Arrival of Patients;
3. Patients Expectations;
4. Emergent, Urgent, and Non-urgent Patients;
5. Assessment, Triage, and Priority Setting:

    5.1 Potential or Sudden Death
    5.2 Alteration in Mental Health
    5.3 Sexual Assault
    5.4 Family/Domestic Violence
    5.5 Disadvantaged Populations
    5.6 Substance Abuse
    5.7 Catastrophic Events
    5.8 Coordination of Multiple Services
    5.9 Multiple Trauma

(NENA Certification Document,1990)

CNA has recognized these as recurrent, unique phenomena specific to Emergency Nursing. Based on these phenomena the CNA acknowleged Emergency Nursing as a specialty and granted certification status. These phenomena will become the foundation and structure for the Emergency Nursing certification exam.

EDNA of Manitoba's position is one of complete and strong support for the continuation of the Manitoba Emergency Nursing Program. In view of our recent national certification status it is crucial to maintain and continue to develop a specific curriculum designed to meet the educational needs of the Emergency Nursing

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practitioner. The present MENP curriculum currently supports the CNA certification requirements. The development of a critical care core curriculum would represent approximately 30% of the present MENP curriculum and current requirements for a practicing Emergency Nurse.

It is with these significant issues in mind that we, EDNA of Manitoba, recommend and request that a current Emergency Nursing expert be involved in the investigation and possible development of a critical care core program. This expert should currently be; 1) employed within the scope of Emergency Nursing (ie. Emergency Clinical Instructor, Emergency Nurse Manager, and/or Emergency Department Staff Nurse) 2) be a graduate of MENP, and 3) familiar with both the current MENP curriculum and the National Emergency Nursing certification requirements. A list of Manitoba's Emergency Nurses with this specific expertise is available upon request.

The EDNA of Manitoba Executive is open to discussion and would strongly encourage a collaborative meeting prior to the final decision regarding the deferment of the 1991/92 MENP class. We would hope and expect that a postponed commencement date is still a possibility (ie. January 1992). Members of EDNA who have applied to the 1991/92 MENP class, have recently been notified that the program is on hold. These members have also been encouraged to apply to other specialty programs, ie. The Adult Intensive Care Nursing Program and/or The Neonatal Pediatric Intensive Care Nursing Program. EDNA membership does not believe these are acceptable alternatives as the curriculum content of both specialty programs will not meet their needs to function in the diverse setting of emergency health care.

The Province of Manitoba, by virtue of the endeavors and accomplishments of EDNA and the MENP of Manitoba, has long been recognized nationally as a leader in Emergency Nursing Education and Practice. They are frequently used as a resource and in the capacity of consultants on issues concerning emergency health care delivery.

We appreciate your attention to this important matter, and await your anticipated reply.

Respectfully yours,

Heather Carlsson-Reid
President, EDNA of Manitoba
on behalf of the
EDNA EXecutive and Membership

encl. Appendix 1
c.c. Please refer to page 5

c.c.
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The Honorable Premier Filmon
Honorable Mr. Don Orchard - Minister of Health, Province of Manitoba
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Mr. Gary Doer - Leader of the Manitoba New Democrat Party
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APPENDIX 1.

NENA

NATIONAL EMERGENCY NURSES' AFFILIATION, INC.

POSITION STATEMENT

ROLE OF THE NURSE IN EMERGENCY NURSING PRACTICE

INTRODUCTION

The role of the emergency nurse is to provide care to individuals of all ages with perceived or actual, physical or emotional, alterations of health that are undiagnosed or require further intervention (Sheehy, 1985). Increasingly, the emergency nurse has been recognized as an effective provider of comprehensive screening, assessment, and management of both acute and chronic illness in the emergency department. For example, Ontario Ministry of Health Statistics indicate that for 230 hospitals in the province, the total number of admissions in 1985/86 was 1,310,031; however, during the same period, emergency visits totalled 5,424,378. Thus, the ratio of emergency visits to hospital admissions is greater than 4:1. This means if a nurse in a hospital setting sees the public as a patient, there is a greater than 4:1 chance it will be an emergency nurse. This example is representative the national trend.

Emergency nursing's uniqueness is practising with a limited data base, in an uncontrolled, unpredictable environment and within a variable time frame. Emergency nursing encompasses expertise from many specialty areas such as maternal/child, medical/surgical, mental health, critical care, ambulatory care, gerontology, and community health. This nurse has a unique contribution to make to emergency care through an ability to address the broad range of patient and family needs which are part of any crisis situation, and to coordinate activities of the emergency care team.

Life-threatening or emergent patients comprise a small percent of emergency census yearly. The emergency nurse becomes a primary health care provider to the majority of the population who seek episodic care. Research done in 1975, (Sheehy, 1985), indicated that the breakdown of emergent, urgent, and non-urgent is as follows:

Emergent	2-5%
Urgent	10-15%
Non-urgent	60-80%

Recent information from selected institutions has indicated that the trends remain similar (Health Sciences Centre. Winnipeg. Manitoba. 1986).

The goal of care and treatment in emergency nursing practice is to stabilize the patient and to refine the initial assessment before moving on to further intervention(s). Care and treatment can range from life sustaining measures through management of common episodic long term problems.

Care and treatment in emergency nursing practice requires that the nurse be able to perform certain independent and collaborative functions. Any decision to implement these functions is made jointly by the local nursing. medical and administrative authorities in the agency.

EMERGENCY NURSING ASSESSMENT.

The priorities of data collection. and formulation of the nursing and medical diagnoses are strongly influenced by the dynamic and highly technological nature of the emergency setting. They are further shaped by the maintenance of biological and phychosociospiritual life.

Inherent in the emergency nurse's role is the ability to organize and store clusters of knowledge to expedite the effective retrieval of information for diagnostic purposes. It then becomes vital that nurses practising in this highly complex area should have expert clinical reasoning abilities to influence patient outcomes.

It is because of the dynamic ever-changing phenomena of the emergency patient and the environment that it becomes essential for the emergency nurse to be able to rapidly identify cues. form those indicators into clusters. and postulate nursing diagnoses.

Effective emergency nursing practice requires the acquisition of specific concepts which are not learned in basic nursing programs. These concepts include primary. focused. and secondary assessment skills and triage. The goal is high quality. accurate assessment which leads to rapid. safe. emergency care while optimally utilizing available resources.

PRIMARY ASSESSMENT - Within the context of a chaotic environment, the nurse must perform a primary assessment on all patients within the first 90 seconds. All factors assessed during the primary survey, such as airway, breathing, and circulation, are of such a critical nature that any major deviation from normal required immediate life-saving intervention. The assessment process should not proceed until all major deviations found in the primary survey have received appropriate intervention. For example, primary assessment will include cervical spine stabilization concurrent with the collection of a brief history of the chief complaint and when it occurred.

FOCUSED ASSESSMENT - Within the context of a chaotic environment, the focused assessment, derived from the primary phase, is more detailed and must be performed within 2-3 minutes. Subjective and objective data is collected during this phase to describe the systems involved in the patient's problem. It is essential that this critical element of assessment be performed and recorded. The assessment process should not proceed until all major deviations found in this focused assessment have received appropriate interventions.

SECONDARY ASSESSMENT - The secondary assessment is a brief head-to-toe assessment performed to discover specific deviations from normal. At this time, a more indepth health history is obtained from multiple sources. This assessment must be performed within 3-5 minutes and may include definitive treatment prior to physician examination.

TRIAGE - Triage is sorting patients according to their acuity and urgency level, processing them into categories, and placing them in appropriate treatment areas. It is the process of deciding the priorities for therapeutic intervention with a given individual or individuals.

(a) Simple Triage - The purpose is to provide the best care for each individual patient. This is used in routine situations. The function of the nurse in this model involves: directing traffic, co-ordinating and controlling the physical environment placement of patients, continual reassessment of the status of the department.

Patients categorized according to the following categories: i) requires life-saving care (emergent): ii) requires care within 15 minutes (urgent): iii) stable in no distress, reassess every 30-60 minutes (non-urgent).
(b) Disaster Triage - This purpose is to provide the most effective care for the greatest number of patients. This type of triage is used for multi-casualty incidents and internal/external catastrophic events. Patients are categorized as: i) emergent; ii) urgent; iii) non-urgent; iv) dead or impending death.

PUBLIC RELATIONS

The health care consumer's initial experience in the emergency department can positively or negatively impact on their perception of the entire hospital. The seemingly chaotic nature of the emergency department can be less frightening to the patient and family when they are received with concern and interest. Therefore, the role that the emergency nurse fills is one of public relations officer for the health care system. This role requires advanced interpersonal and communication skills to interact with clients and the community These are not acquired in a basic nursing program.

The emergency nurse interprets the role and function of nurses, physicians, and other health care team members to the patient and family members. In essence, the emergency nurse has the unique opportunity to act as the health care system's ombudsman.

FAMILY AND PATIENT EDUCATION

All patients and families have a need for health promotion and disease prevention information. This basic information is provided through pamphlets, video presentations posters in the support areas of the emergency department.

Due to the chaotic nature of the emergency setting, all teaching opportunities must be brief in nature. Not only is this opportunity brief, but it may be the only contact the patient has with the health care system.

This requires that the emergency nurse quickly assess educational needs and plan strategies that will be effective for that unique situation. They then efficiently teach what is necessary for those patients to learn. Many of these plans are non-traditional in nature and cannot be pre-planned or predicted. Therefore, it is difficult to have written plans that would convey every situation. The nurse must have an indepth understanding of learning and motivation, and learning under stress.

Since a significant percentage of patients seen in the emergency setting return home immediately upon receiving care, a sound knowledge of community resources and the ability to access them appropriately is essential.

CRISES INTERVENTION

Crisis intervention is an active but temporary entry into the life situation of an individual, a family, or a group during a period of stress (Human, 1984). It is an essential ongoing component of emergency nursing practice.

No matter how minor a patient's condition, the situation is perceived by both the patient and family as a crisis or emergency. The emergency nurse must be alert, flexible, resourceful and willing to take an active role to intervene in the crisis situation in order to obtain an adequate amount of information, so that a basic medical/nursing diagnosis of the crisis can be made. A co-operative working relationship with the patient must be established quickly so that a possible plan of action can be developed. The usefulness of this plan depends on the trust relationship developed between the patient and nurse, and on its congruency with the initial assessment of the problem.

On initial contact with the patient, the emergency nurse must alleviate the patient's anxiety prior to collecting data. Responsibility rests with the emergency nurse to evaluate how the patient and family are coping prior to discharge. Crises are time-limited. In most cases, a nurse will only have an hour or less to intervene. This limits the efforts to the immediate problem and to the directly related behaviours.

EMERGENCY NURSING LEGAL RESPONSIBILITIES

Along with hospital policies, the emergency nurse must demonstrate an awareness of current federal, provincial and local laws governing the delivery of care to the patient. The nurse must be cognizant of specific new legal protocols such as obtaining specimens for forensic purposes or restraining patients on an involuntary basis.

Documentation of patient care in the emergency department is unique, since there is evidence to suggest that the emergency environment is predisposed to a higher incidence of lawsuits (Wiebe, 1988). It is vital for the emergency nurse to be thorough, succinct, and non-judgemental when charting. Systematic efficient charting tools provide for records of primary, focused and secondary assessments on a variety of patient health care problems. These records may be important for the nurse if she is called on as an expert witness or as a defendant.

Due to the nature of the emergency clientele, there is increased opportunity for litigation. The emergency nurse must have more than a basic understanding of legal procedures, and must integrate hospital policy with various laws. It is important that emergency nurses become aware of potential litigation and avoid making subjective statements or behaving in a manner that could become grounds for legal action.

ETHICAL RESPONSIBILITIES

The unique entity regarding ethical decision making in emergency nursing is the limited time frame and the chaotic environment within which the nurse works.

Emergency environments predispose the nurse to a multiplicity of ethical issues, i.e.: miscarriages, DNR orders, AIDS, reporting and treating violent offenders, and aggressively managing the chronic, debilitated and terminally ill.

The emergency nurse in this complex environment has limited time to gather data in order to provide a foundation on which to make a decision. Further, the nurse must rapidly select information from that narrow data base in order to identify and clarify ethical components of a given dilemma.

Also, the emergency nurse does not have an abundance of time to become assertively involved with analyzing the rights, duties, authority and capabilities of all decision makers and this may lead to conflict regarding the nurse's moral authority.

When choosing alternatives as it relates to a given situation, the time factor also places limits on how indepth the comparison will be.

ADVOCACY

The emergency nurse is in a unique position to identify and intervene with vulnerable populations upon their arrival in the emergency department. Patients such as battered wives, rape and trauma victims, hostages, and the "abandoned" elderly often lack the support of that which is needed to endure and are under pain, duress, or coercion. Coupled with the loss of independence and individuality, the patient may feel he has lost the ability to make choices in his life. Foreseeing, forecasting, and preventing problems is a method whereby the emergency nurse intervenes and reduces the need for advocacy in a crisis situation.

Because of the nature of the emergency environment, the emergency nurse acts as an advocate for the undiagnosed patient and his family with the physician. As the emergency physician is not known to the patient, the interactions are time limited, the nurse continually transmits current and accurate information about the patient's plan of care. The nurse also ensures that all appropriate care modalities are employed within the fast paced seemingly fragmented arena of the emergency department.

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